

**DELINEATION OF CLINICAL PRIVILEGES - PHYSICAL THERAPY***(For use of this form, see AR 40-68; the proponent agency is OTSG.)*1. NAME OF PROVIDER *(Last, First, MI)*

2. RANK/GRADE

3. FACILITY

**INSTRUCTIONS:**

**PROVIDER:** Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

**SUPERVISOR:** Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

**PROVIDER CODES**

- 1 - Fully competent to perform
- 2 - Modification requested *(Justification attached)*
- 3 - Supervision requested
- 4 - Not requested due to lack of expertise
- 5 - Not requested due to lack of facility support

**APPROVAL CODES**

- 1 - Approved as fully competent
- 2 - Modification required *(Justification noted)*
- 3 - Supervision required
- 4 - Not approved, insufficient expertise
- 5 - Not approved, insufficient facility support

**SECTION I - CLINICAL PRIVILEGES****Category I.**

Routine physical therapy evaluations and procedures expected of a graduate physical therapist.

Requested	Approved	
		Category I clinical privileges

**Category II. Special Privileges - includes Category I.**

Requires additional skill level as demonstrated through documented additional training and practical experience.

Requested	Approved		Requested	Approved	
		Category II clinical privileges			e. Assign quarters up to 72 hours
		a. Electroneuromyographic (EMG) testing			f. Refer to specialty clinics, as appropriate
		b. Early intervention for high-risk infants			g. Prescribe P&T committee approved medications
		c. Request appropriate imaging studies			
		d. Recommend limited duty profiles <i>(not to exceed 30 days)</i>			

**COMMENTS**

SIGNATURE OF PROVIDER

DATE (YYYYMMDD)

**SECTION II - SUPERVISOR'S RECOMMENDATION**Approval as requested ☐Approval with Modifications *(Specify below)* ☐Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*

SIGNATURE

DATE (YYYYMMDD)

**SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION**Approval as requested ☐Approval with Modifications *(Specify below)* ☐Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*

SIGNATURE

DATE (YYYYMMDD)

**EVALUATION OF CLINICAL PRIVILEGES - PHYSICAL THERAPY***(For use of this form, see AR 40-68; the proponent agency is OTSG.)*

1. NAME OF PROVIDER <i>(Last, First, MI)</i>	2. RANK/GRADE	3. PERIOD OF EVALUATION <i>(YYYYMMDD)</i> FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY <i>(Name and Address: City/State/ZIP Code)</i>	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

**SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION**

CODE	PRIVILEGE CATEGORY	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	Category I clinical privileges			
	Category II clinical privileges			
	a. Electroneuromyographic (EMG) testing			
	b. Early intervention for high-risk infants			
	c. Request appropriate imaging studies			
	d. Recommend limited duty profiles <i>(not to exceed 30 days)</i>			
	e. Assign quarters up to 72 hours			
	f. Refer to specialty clinics, as appropriate			
	g. Prescribe P&T committee approved medications			

**SECTION II - COMMENTS** *(Explain any rating that is "Unacceptable".)*

--	--	--

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE (YYYYMMDD)
-----------------------------	-----------	-----------------